CALIFORNIA CABG OUTCOMES REPORTING PROGRAM

(Last Revised 10/07)

Healthcare Information Division
Healthcare Outcomes Center
400 R. Street, Room 250
Sacramento, California 95811
(916) 326-3861 FAX (916) 445-7534

Extension Request Form

Hospital Name: _____

Facility ID: _____ Report Period: (Begin/End Date): _____

Date: _____ Number of Days of Extension Request: _____

Justification for Extension Request:

(Include the factors that prevent completion of the report by the due date, and actions/time needed to accommodate those factors)

Extension request submitted by:

_____
Name and Title (Please print)

_____ _____
Phone number Fax number

_____
Signature

OSHPD USE ONLY

Extension Request (circle one): Granted Denied

REVISED DUE DATE: _____

By: _____ **Date Approved:** _____

(A formal notification of extension request approval or denial will be sent via certified mail)